Nutritional Questionnaire

Name: _____ Date: _____

In your own words, please give your reasons for wanting a nutritional consultation? _____

_____

_____

_____

_____

What are your current symptoms? (ex digestive symptoms, pain, bloating, reflux, flatulence, pain in the joints and muscles, low energy levels, headaches, sleep problems, memory problems, general decrease in ability to function etc.) _____

_____

_____

_____

_____

How often do you have a bowel movement and what best describes it?(easy or difficult to pass etc.) _____

_____

What do you think is the underlining problem? _____

_____

What do you think caused your current health condition? _____

_____

Do you believe healthy food can positively affect your health and mental wellbeing? _____

What is your view of a healthy well balanced nutritional diet?_____

_____

What are your daily activities? _____

_____

How often in one month do you cook at home for you and your family? _____

How often in one month do you eat out in restaurant? _____

What foods do you seem to be drawn to eat? _____

_____

What foods do you think you do not tolerate well and why? (What reaction occurs or how do you feel when you eat them?) _____

_____

How much water do you drink each day? _____

Past Health History:

Did your mom have any problems during her pregnancy with you or during labor with you?

_____

_____

Were you born on time or premature? _____

Were you breastfed as a baby and for how long? _____

Did your parents tell you of any health problems you had in your first year of life? _____

_____

_____

Any problems in the second year? _____

_____

Any problems later in childhood or early adulthood? _____

_____

Were you a colicky baby or crying baby? What vaccinations did you have? _____

_____

Did you have any reactions to any vaccinations, antibiotics, introduction to solid foods etc? __

_____

_____

Did you have normal or delayed milestones? (ie crawling, walking, talking) _____

_____

_____

_____

Tell me about any other health issues you have had in the past. (Any medical procedures, operations, or medications) _____

_____

_____

_____

What was your professional occupation and what health risks do you think you have been exposed to? (Ex. toxic substances, excessive stress, lack of sleep etc) _____

_____

_____

_____

Do you have any mercury amalgams, root canals, extractions, crowns, or braces in your mouth? _____

_____

Tell me about your immediate families health (parents, siblings, and children)_____

_____

Did your parents have any health concerns prior to or while conceiving you? (Ex. Eczema, asthma, IBS, digestive problems, migraines, PMS, chronic fatigue, hay fever, hormonal abnormalities, thyroid and adrenal problems etc.) _____

_____

_____

If you know, please list any health concerns of your grandparents. _____

_____

Would you consider your childhood to have been a happy one? _____

How did you do at school? _____ Did you enjoy school? _____

Do / Did you enjoy your work? _____

How would you describe your family / home life now? _____

_____

Anything else you would like to add so we can best serve you? _____

_____